Utah Digital Health Service Commission Meeting
Thursday March 6, 2014, 10:00 a.m. – 12:00 p.m.
Utah Department of Health, 288 North 1460 West, Rm 114, Salt Lake City, Utah

Minutes

Members Present: Deb LaMarche (Chair), Scott Barlow, Mark Dalley, Henry Gardner, Dennis Moser (via phone), Marc Probst, Jan Root (Vice Chair), Nancy Staggers (via phone), and Sarah Woolsey
Members Absent: Craig Herzog, Chet Loftis
Staff Members: Humaira Shah and Wu Xu (UDOH)
Guests: David Cope (Cope Family Medicine), Courtney Dinkins (AUCH), Jeffrey Duncan (UDOH), Mark Fotheringham (UMA) (via phone), Charlene Frail-McGeever (UDOH) (via phone), Justin Kahn (TruClinic), Rich Lakin (UDOH), Wyatt Parker (HealthInsight), Nicholas Price (Cope Family Medicine), Ruben Rocha (Salt Lake Community College), Robert Rolfs (UDOH), Iona Thraen UDOH)

Introduction and Welcome:

Deb LaMarche began the meeting and asked for a motion to approve January minutes and it was passed. Membership and nomination were added to the agenda and she announced that Wesley Smith has resigned from the commission due to a role change, moving to the governor's office. If anyone has any interest or nomination recommendations let Wu Xu know. Wu mentioned that the commission would have some reappointments and needed nominations for other positions as well.
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Legislative Updates:

Wu Xu provided legislation updates: 1) Rep. Menlove's H.B. 92 Utah Education and Telehealth Network Amendments and 2) Rep. Dunnigan's H.B.141 Health Reform Amendment. Both of the bills were passed.

Recap the Discussion at the Last Meeting

Deb summarized that there were three main presentations: Jan Root gave a good presentation on Health Information Exchange, description of both private and community based exchanges and their roles. She discussed different models and the big news was the UHIN board of directors had voted to change the consent model of the cHIE to a HIPPA consent model. The second interesting presentation was from Scott Afzal representing Information Exchange in Maryland. They had a good model that was successful for them. Sid Thornton from Intermountain gave a presentation on getting the cHIE to work as intermountain expected. He discussed a lot of the challenges and the role for the cHIE and one would be the importance of having a State Master Person Index. Recommendations need to be made and the two issues were: Do we still support the importance of having a community based Health Information Exchange? And we need to summarize some of the key purposes and challenges of that exchange.

Meaningful Use Stage 2: New Requirements and Challenges

Rich Lakin and Wyatt Packer presented. Rich is the EHR incentive program manager and began with some overview of information. The objectives are discussed and relate to reviewing the impact of Meaningful Use, providing refreshers and updates. Priority areas of MU are discussed; improving

quality, safety, efficiency, care coordination, and population and public health as well as engage patients in their health care and ensure adequate privacy and security protections for personal health information.

Meaningful Use stages are discussed; 2011 Stage 1 is data capture and sharing, 2014 Stage 2 is advanced clinical processes, 2017 Stage 3 improved outcomes.

What is next is discussed. 2014 certified EHR technology is required for both Stage 1 and 2, and will require additional features. All EHR systems need to be updated to the 2014 requirements to pass for Meaningful Use Stage 2. Deb asked if the majority of Utah providers have EHRs that will be able to meet the certification requirements? Currently for the 2014, no, not a lot of systems are yet available for updates and most providers are using previous certification systems but it will become available over time.

Rich mentioned if 90% or more of their business is with the inpatient setting then they are covered under MU with the inpatient organization and there is a 1-3% penalty of Medicare reimbursement. Stage 2 increases the requirements for coordinating care transitions electronically. Summary of care is required to be transmitted electronically either from one EHR system to another using certified EHR technology. There is a need for additional knowledge around the Direct Program and EHR requirements and a lot more to be learned. EHR doesn't have to provide Direct; the providers just have to be able to do it Jan commented. Public health reporting is discussed and Stage 2 increases reporting requirements with labs, immunizations, and cancer registry. The value of public health measures has two items, the first one is showing clinical lab test results coming into an EHR system and the capability to submit electronic data to immunization registries/systems. The last topic discussed is patient engagement through Health IT. Stage 2 supports increased engagement with patients through portals and other elements. Wyatt wanted to focus on the barriers from consumer and provider perspectives. The gaps and challenges of MU are 1) specialty providers with slower adoption, 2) additional time spent by providers to document MU, and 3) no incentive or support for nursing homes, home health for HIT adoption. The Health IT adoption/ MU challenges are financial, technical, and cultural in nature. These will impact our healthcare system. Meaningful Use is a building block; Stage 3 will drive to improve outcomes.

The State Innovation Model (SIM) grants:

Iona Thraen discussed the planning for the SIM test grant. The elements of the SIM plan are mentioned. The purpose of the plan is to transform the healthcare environment towards about 80-85% of state population into this value-based payment method within 3-5 years.

The aim covers four areas; value based purchasing, behavioral health integration, end of life care, and community health workers. The infrastructure was an abstraction out of these aims. The SIM plan comes out with a $44 million estimate for the aims plus administrative overhead and that's not feasible given the size of our state. One of the questions is how do we pull back about $10 million on this plan? Information technology is a core infrastructure in achieving the ends. The emphasis on HIT includes patient population management and quality metrics, patient engagement and self-management, privacy and security of health information. Is this something that the state of Utah wants to keep 40% of this grant on and IT level? Is this reasonable? Are there some priorities that could be set or core infrastructure pieces? She asked for thoughts and feedback.

Jan said when you look at other SIM grants that have been approved, there is a lot of IT in all of them. Iona said IT and workforce was CMS focus, the workforce piece in this focus comes out of the

community health workers and also in terms of bringing behavioral health which has been lacking in Utah. It needs to be addressed in the state.

Wu said Currently APCD has two other CMS grants for two years and the APCD line items could be reduced. Iona mentioned Wyatt said before the meeting that maybe the security system request might have changed some and Jan said yes it has. It has developed a more vigilant monitoring of the small guys' systems.

Henry Gardner commented that one of the gaps is the EHR system still lacks functionality. Isn't this the core of what it's all about, to get these EMR's to talk to each other and function? That's where the emphasis on the funding needs to be. A lot of the dollars need to be functioned to get this thing functional.

Marc Probst asked is this federal grant money and have we gotten it? Jan answered, no we are still waiting. Marc said he's not sure if aligning everything is MU requirement or just aligning everything is aggressive enough for us as a state. Jan commented some other states are trying to pursue that goal. Medicaid, Chip, and PEHP are the big state expenditures as well as uncompensated care. MU is fabulous but the state itself could take a much more assertive role in developing funding streams. This is an opportunity for the DHSC to make a recommendation that the legislature take a more active role.

Deb asked if anyone in the commission would be interested in being part of a work group to work with Iona and her team on the priority list? Wu said she would get that organized with Iona.
Wyatt wrapped up his discussion. He asked how can Utah and the DHSC best support providers and the health care system as we roll into Stage 2 and as we advance in payment and delivery redesign. He asked for some thoughts and recommendations. He gave some recommendations for the DHSC and where they can have an impact in 12 months which were shown in his slides.

Meaningful Use User's Comments:

Dr. Cope made comments: I think that the providers in general are on board and there is not great resistance. As we talk amongst ourselves there is an awareness of the need and benefit. There is a hurdle in the paradigm shift to start doing that [EHR] but it was rapidly showed how beneficial that was. My patients really enjoyed that and gave feedback on it. We all have had that experience when our providers have given that summary of care. If there is some way to implement this in daily use that would be good, everyone having access to EHRs. There are frustrations that do come along with it, maybe a public awareness campaign would be beneficial.

Dr. Rolfs asked how many people in the practice actually have a sense of where this is headed and what helps them to overcome the day to day frustrations? Dr. Cope said there are 8 providers in the clinic and he does have some of the background stuff, 1-2 other provides have a good understanding, and there are others who are just frustrated.

Sarah Woolsey commented the big picture inspires people when they hear outcomes but right now it's hard to see that especially when payers are talking about paying differently.

Iona said one of the things they were doing in their framework, was looking at the data and see where are high volume and high cost areas and to try to form directions. Henry commented that we have more opportunities in Utah to solve problems because we have cooperating communities.

Nicholas Price commented from what he's seen from the technical side of it: It's just not there. We are meeting MU things but I can't make system reports on every one of them [measures]. Wyatt and Rich can assist with that because they found all the pieces. On the financial side, our EMRs are a great way to make money.

Justin Kahn commented that there are companies out there that we've been meeting with them to do EHR trainings. They train different levels of the staff and provide back channel support. That might be something you can put into your budget and bring in contractors to do it. HC tech is a company that does all the big ones.

Mark Dalley said things [in rural areas] are very different from what this group is working on. There are 9 hospitals in the state that are not affiliated with a system at all. They are community hospitals. Most of these hospitals look at MU as a way to help fund an EMR into their hospital. The great good will come someday from getting the system in. We struggle with having money to put systems in. We are all on different systems. How does information get to Intermountain facilities? We don't have the ability to send stuff to them and we can get some information back from them but we don't have the ability to electronically transfer stuff. We are not thinking about value-based purchasing in small hospitals; we are thinking how do we get this system in place and avoid penalties, and how do those systems communicate with one another.

Summarize the Discussion:

Deb mentioned she would like to focus on the rural and small providers in the May meeting, Discussing the hospitals, independent practices, community health centers that are out in the middle of nowhere. You each have your own needs and requirements but that commonality of you are only having one technical support person. She read through the proposed policy recommendations from the last HIE discussion. This is a starting point and we can add and include other suggestions. The statewide health information exchanges HIE is an important component for the state to support the deliveries of coordinated and efficient healthcare to all Utahns. Utah has made significant progresses in developing and implementing a statewide HIE in the past 5 years. The UDHSC recommends the UDOH and the state of Utah to 1)continue its support for the community-based, not-for-profit HIE initiative and 2) pay special attention to small independent and rural providers' connectivity to the state designated not-for-profit HIE. This is something as a group we have to decide if we want to support, modify, or add to. If we can come to a consensus it is something we can provide from our diverse perspectives we have. We will revisit this in the next meeting.

Meeting adjourned.